Montana Medicaid
CLAIM JUMPER

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RHC Services in Hospitals

Effective October 1, 2007, RHC services are not covered by Montana Medicaid when provided to a hospital patient.

Submitted by Bob Wallace, DPHHS

NDC Requirement on All Physician-Administered Drugs

Montana is requesting a waiver extension for the federal NDC requirement for physician-administered drugs. We will notify you through the *Claim Jumper* newsletter if this waiver is received. Without an extension, Montana Medicaid will require all claims submitted for physician-administered drugs to include the National Drug Code (NDC), the corresponding HCPCS code, and the units administered for each code.

Montana Medicaid will reimburse only on drugs manufactured by companies that have a signed rebate agreement with the State of Montana.

Claims for physician-administered drugs are reimbursed using HCPCS codes. Units are to be reported according to HCPCS codes as well as NDC code. The Department collects drug rebates based on the NDC code and units administered. The Deficit Reduction Act of 2005 (DRA) includes new provisions regarding State Medicaid collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for physician-administered drugs.

NDC Information

A drug's NDC is the 11-digit code assigned to all drug products by the labeler or distributor of the product under FDA regulations. The code consists of three segments (see sample below):

12345	6789	10
Labeler	Product code	Pkg. code

- The first segment, the labeler code, is assigned by the FDA. A labeler is any firm that manufactures (including repackers or re-labelers) or distributes (under its own name) the drug.
- The second segment, the product code, identifies a specific strength, dosage form, and formulation for a particular firm.
- The third segment, the package code, identifies package sizes and types. Both the product and package codes are assigned by the manufacturer.

Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause the Department to report false data to drug manufacturers billed for drug rebates and will delay reimbursement to the provider.

For more information, read the complete notice on www.mtmedicaid.org.

Submitted by Pat Osterhout, DPHHS

Billing With an NPI

Montana's Healthcare Programs began accepting National Provider Identifier (NPI) from healthcare providers as of October 1, 2007. (Atypical providers, i.e. taxicabs, personal care, assisted living, are not required to bill with an NPI but can if they have obtained one.) Based upon our review of the claims, ACS has the following suggestions to ease the transition to NPI only. Remember, the contingency for Montana's Healthcare Programs ends when Medicare's contingency ends, on December 31, 2007, for providers billing on the UB form or 837I electronic transaction, and March 1, 2008, for fee-for-service claims.

Please note that prior to NPI implementation, the MMIS used only a single provider ID to process the claim. If a rendering provider ID was sent, this was the ID used to process the claim. With NPI, the MMIS now pulls in both the billing provider ID as well as the rendering provider ID. Providers must, therefore, be extremely careful to use the correct IDs in these fields to avoid claims processing problems.

Only the provider types listed below should bill one provider number/NPI as the billing provider and a different provider number/NPI as the rendering provider. If you are not one of the provider types below, you are both the billing provider and the rendering provider.

- Podiatry Clinic
- Physical Therapist Clinic
- Speech Therapist Clinic
- Occupational Therapist Clinic
- Dental Clinic
- Physician Clinic
- Dedicated Emergency Department
- General Group or Clinic

Below are some tips for specific provider types that have been using incorrect rendering provider information on their claims. Please follow these guidelines to avoid claim denials:

- **Federally Qualified Health Centers (FQHC).** If any of your physicians see patients in another setting, e.g. hospital, the physician is both the billing and rendering provider or the hospital is the billing provider and the physician is the rendering provider in this case. Do not bill yourself as the billing provider and the physician as the rendering provider.
- **Ambulance Providers.** You should not indicate the physician who gave orders for the patient or requested the patient be transported via ambulance. The ambulance provider rendered the emergency transportation services and is, therefore, the rendering provider.
- **DME Providers.** You should not indicate the physician who wrote the orders for DME equipment. The DME provider dispensed the equipment to the patient and is, therefore, the rendering provider.
- **Ambulatory Surgical Centers.** You should not indicate the physician who performed the surgery as the rendering provider. The ASC is providing the facility and equipment and is, therefore, considered to be the rendering provider. The physician will separately bill for the surgical services rendered.
- **Nursing Facility Providers.** Nursing facilities may reenroll using their nursing facility NPI for physical, occupational and speech therapies and pharmacy, if they provide those services. You should not bill for therapy services using your nursing facility NPI and the therapist as the rendering provider. The nursing facility will bill the NPI and taxonomy from the reenrollment for the service being billed as the billing provider. Individual therapists should be enrolled using their own NPI and taxonomy and be submitted as the rendering provider on the detail line.

DO:

- Apply for an NPI from the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203, customerservice@npienumerator.com or NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.
- Reenroll with Montana's Healthcare Programs at www.mtmedicaid.org or contact ACS Provider Relations at 1-800-624-3958 for assistance. Begin billing with your NPI only so there is less chance your claims will be denied or payments delayed before the contingency ends.
- Submit a few claims with NPI and taxonomy only (no legacy CHIP/MHSP/Medicaid ID) to ACS to allow time to resolve issues before the contingency period ends.
- Bill either the NPI in Box 56 or the legacy Medicaid ID in Box 57 if submitting a UB-04 claim.

DO NOT:

- Bill an NPI in Box 17A for the Passport provider number as the claim will deny if Passport authorization is required.
- Bill your legacy Medicaid ID as the billing provider in Box 33B and your NPI as the rendering provider in Box 24J. Bill either the legacy Medicaid ID or the NPI in both places.
- Put both your NPI in Box 33A and your legacy Medicaid ID in Box 33B. Box 33A should contain the NPI of the billing provider and Box 33B should contain qualifier "ZZ" if taxonomy is billed or Box 33B should contain qualifier "1D" if the legacy Medicaid ID is billed and Box 33A should be blank.

CHIP Extended Dental Benefit

The Children's Health Insurance Plan (CHIP) implemented an Extended Dental Benefit plan effective October 1, 2007. The response to the program which increased dental benefits for children with significant dental needs, is remarkable, said CHIP Dental Manager Barb Arnold. More than half of the program's limited funding is already committed, she said.

Dental providers should submit the "Request for Extended Dental Benefits" by FAX to CHIP at 1-877-418-4533. CHIP must approve the Extended Dental services **before** the child is eligible for these benefits. Providers must verify the child is CHIP eligible in the month the dental services are provided to guarantee payment.

Extended Dental claims are not yet processing correctly; however, ACS staff is working to address these issues and expects a resolution shortly. Submit all Extended Dental Claims to ACS, PO Box 8000, Helena, MT 59604.

Submitted by Barbara Arnold, CHIP Dental and Eyeglass Manager

Carisoprodol (Soma®) Containing Products to Require PA

The Medicaid Drug Utilization Review Board has unanimously recommended prior authorization for carisoprodol-containing products based on a review of the evidence and literature. Carisoprodol is metabolized to the sedative meprobamate, a schedule IV controlled substance associated with the potential for dependence and addiction.

Effective January 2, 2008, Montana Medicaid will be implementing the following Prior Authorization Criteria for the use of carisoprodol containing products:

- New prescriptions—Patient must have tried and failed on a least two other centrally-acting muscle relaxants (i.e. methocarbamol, tizanidine, cyclobenzaprine, orphenadrine, chlorzoxazone or Skelaxin®).
- Prior authorizations may be granted for a maximum of 84 tablets in a six-month time period.
- Renewal requests—A 30-day authorization will be granted for patients currently taking carisoprodol to allow for a tapering schedule. Patients on high doses may suffer withdrawal symptoms if stopped abruptly. Cases may be reviewed on an individual basis to allow for a longer tapering period.

The prescriber (physician, etc.) or pharmacy must submit the information requested on the Request for Drug Prior Authorization Form by mail, telephone, or fax to Drug Prior Authorization Unit, Mountain Pacific Quality Health Foundation, 3404 Cooney Drive, Helena, MT 59602; (406) 443-6002 or (800) 395-7961 (phone); (406) 443-7014 or (800) 294-1350 (fax).

Submitted by Wendy Blackwood, DPHHS

Publications Reminder

It is providers' responsibility to be familiar with Medicaid manuals, fee schedules, and notices for their provider type, as well as other information published in the ***Claim***

14,250 copies of this newsletter were printed at an estimated cost of $.36 per copy, for a total cost of $5,174.93, which includes $2,197 for printing and $2,977.93 for distribution.

Alternative accessible formats are available by calling the DPHHS Office of Planning, Coordination and Analysis at (406) 444-9772.

Jumper and on the Medicaid website (mtmedicaid.org).

Cost Share Changes

Changes have been made to cost share in the emergency room. Before the change, a list of procedure codes that were always emergent was in place. This emergent list was used to determine reimbursement and to exempt cost share on emergency room claims. Critical Access Hospital claims were exempt from the emergent list. Now, CMS-1500 claims with a place of service 23 and outpatient and inpatient UB claims with a 45X or 68X revenue code are deemed to be emergent and are exempt from cost share. The effective date of this change was January 1, 2007. However, the change was not implemented until July 20, 2007. A mass adjustment of claims is planned for those emergency room claims with dates of service and date processed between January 1, 2007, and July 20, 2007.

Submitted by Bob Wallace, DPHHS

Alcohol/Drug Detox Medicaid Monies Recovery

Medicaid recently found some inpatient hospital claims for alcohol and/or drug detox that had a length of stay over four days and were not prior authorized. Per ARM 37.86.2902—INPATIENT HOSPITAL SERVICES, REQUIREMENTS:

"(4) Alcohol and drug treatment services are limited to: (a)detoxification services up to four days, except that more than four days may be covered if concurrently authorized by the designated review organization and a hospital setting is required; or (b)the designated review organization determines that the patient has a concomitant condition that must be treated in the inpatient hospital setting, and the alcohol and drug treatment is a necessary adjunct to the treatment of the concomitant condition." This information can also be found in the Hospital Inpatient Services provider manual.

The Department has completed a post payment review and will be recovering monies spent in error for those alcohol/drug detoxification claims that were paid for lengths of stay over four days without a prior authorization.

Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, download the complete document from www.mtmedicaid.org, the Provider Information website. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website

Date	Provider Type	Description
Notices and Replacement Pages		
11/13/07	School-Based Services	New Rates
11/27/07	All Provider Types	Cost Share Changes
11/29/07	Audiology, Hearing Aids	Rate Increase
Fee Schedules		
11/14/07	Home Infusion Therapy	Fee schedule
11/20/07	Dentist, Dental Hygienist, Denturist, Ambulance, Oral Surgeon	Fee schedules
11/21/07	Physical Therapy, Occupational Therapy, Speech Therapy, Optician, Optometric, School-Based Services, Eyeglasses	Fee schedules
11/29/07	Audiology, Hearing Aid	Fee schedules
Other Resources		
11/05/07, 11/12/07, 11/19/07, 11/26/07	All Provider Types	What's New on the Site This Week
11/13/07	All Provider Types	December *Claim Jumper*
11/13/07	All Provider Types	NPI Contingency Plan Certification added to Forms page
11/14/07	School-Based Services	CSCT FAQs and Power Point
11/14/07	Dentist, Denturist, Oral Surgeon	Dental claim form
11/20/07	All Provider Types	News item regarding Pharmacy Lockin for Team Care Clients
11/20/07	All Provider Types	Vendor information updated on Tamper-Resistant Pad Vendors page
11/27/07	All Provider Types	News item regarding eSOR Delay

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Key Contacts

Provider Information website: http://www.mtmedicaid.org
ACS EDI Gateway website: http://www.acs-gcro.com
ACS EDI Help Desk (800) 624-3958
Provider Relations
(800) 624-3958 (In and out-of-state)
(406) 442-1837 (Helena)
(406) 442-4402 Fax
Email: MTPRHelpdesk@ACS-inc.com
TPL (800) 624-3958 (In and out-of-state)
(406) 443-1365 (Helena)
(406) 442-0357 Fax
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-Sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 362-8312
Prior Authorization
Mountain-Pacific Quality Health Foundation (800) 262-1545
Mountain-Pacific Quality Health Foundation—DMEPOS/Medical
(406) 457-5887 local, (877) 443-4021, ext. 5887 long-distance
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
Helena, MT 59604

Third Party Liability
P.O. Box 5838
Helena, MT 59604